LEGACY
MENTAL HEALTH CENTER

Authorization for Two-Way Release of Confidential Information

_____ _____

Name **Date**

I hereby authorize _____ to release the following information about me.

- ___ Brief Summary of My Record
- ___ Medical Records
- ___ Chemical Dependency Treatment
- ___ Juvenile/Adult Court Records
- ___ Records of Hospitalization
- ___ Psychological Testing
- ___ Progress Report
- ___ Discharge Summary
- ___ Diagnosis
- ___ Social or Family Casework Record
- ___ Other: _____

To the following agency or individual _____

The purpose of the information is:

- ___ Coordination of Treatment Planning
- ___ Evaluation
- ___ Other: _____

I understand that this release authorizes two-way contact between _____ and the other named organization or individual and that no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to the information will be limited to persons whose work assignments reasonably require access to accomplish the purposes stated above.

I understand that a photocopy of this release shall be effective for this purpose as the signed original.

I understand that I may revoke this consent in writing at any time and that, in any event, it expires automatically within one year of this date or when the purposes for which it was granted have been accomplished, whichever occurs first.

Signature of Client/Guardian	Date